HEAD OF ADULT SERVICES

ANNUAL REPORT
2013 – 2014

The Adult Services Division provides services for people with a learning disability, autism, mental health problems, frailty because of ageing, a physical disability or sensory impairment and adults who need protecting from abuse.

www.valeofglamorgan.gov.uk
01446 700111

Contents

Context

1. Adult services support people with mental ill health, learning disabilities, physical disability, sensory impairment and frailty or/and mental health issues associated with ageing. £35 Million was spent on these services in 2013/14. The division made significant savings throughout the year and provides greater levels of care at home for the same overall cost as the previous year. This is in line with the Council's difficult financial position brought about by cuts to its budget.

2. When social services get a request for help, social workers and our partners in other agencies carry out unified assessments with potential service users and (where appropriate) their carers. Support from family carers is often the most critical factor in helping people to remain as independent as possible; social services try to add to this help, not replace it. Based on the assessments, packages of care are developed in response to the needs which have been identified. Adult Services have a statutory responsibility to help meet this level of need through the provision of social care and support. An important role is to ensure that people can get access to other service provision (e.g. housing, education, employment support) where this has been identified as an area for action within the assessment process.

3. The work of adult social services in meeting service users need cannot be done in isolation. It is especially important that we continue to develop our partnership working with the NHS, housing, the police, the third or voluntary sector and independent providers of services. These strong and purposeful partnerships help to ensure that:

   - agencies are all moving in the same direction and assisting each other to meet key goals (e.g. safe discharge from a stay in hospital);
   - effective communication takes place; and
   - funding is used properly.

   The work on integrating social care and health services continues at pace with jointly run and co-located services becoming more common. This year has also seen the development of an ambitious locality plan which sets the longer-term framework for this process of integration.

4. The scale of the support made available to vulnerable people in need of social care is shown by the following data for the twelve months from April 2013 to March 2014.

Key adult social services activity data 2013/2014

The figures for the previous year are in brackets.

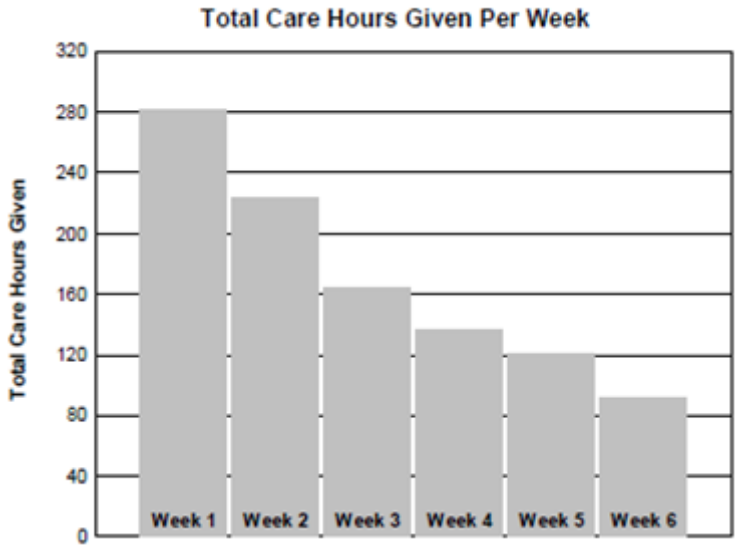
- 1822 people were supported to live at home (1690)
- 250 people received individualised Telecare support (269)
- 1141 older people were helped to live at home (1107)
- 384 older people were supported in residential/nursing home care (394)
- The rate of delayed transfers of care for social care reasons per 1000 of the population aged 75 or over was 7.35 (6.5)

5. Adult Services continue to go through a period of significant change. One of the key priorities currently is the transformation of services for older people. There has been good work done in joint health and social care 'frailty programmes' across Wales, including the Wyn campaign in the Cardiff and Vale area. However, older people still experience too much fragmented care which confuses and frustrates recipients and providers alike. It's inefficient, over-reliant on crisis responses and too liable to produce detrimental outcomes for older people. We need to replace these old systems and services.

6. For this reason, all the partner organisations in the Vale of Glamorgan have come together to set out a clear direction for the changes needed. This means a completely unified approach to delivering adult social care and community health services for older people – with prevention, early intervention, reablement, intermediate and long-term care as part of a single, co-ordinated and community-based system. This is the model that older people want and need to experience, one that is designed to give them a say and the chance to retain control of their lives while providing support and care that guarantees their rights and dignity.

7. In 2013/14, we have been fortunate to get an additional grant through the Regional Collaboration Fund to enhance reablement services and deliver

improved response times. Reablement services play an important role in helping people to re-learn the skills necessary for daily living lost through deteriorating health or increased need for support. They help to ensure that people can return safely to their communities (after a hospital stay, for example), rebuild their lives and avoid institutional care. Improvements have been made to the systems for collecting information that allows us to measure properly the extent to which we have been able to increase individual independence. Overall outcomes are very positive, with over 80% of people who received the service having improved levels of independence. The graph below shows the improving levels of independence achieved throughout the period that people receive support. The amount of care needed reduces as levels of independence improve.



8. One of the ingredients which makes reablement services so effective is the way people work together: the service user is a full partner with staff from statutory services, voluntary and independent sectors, all aiming to help them reach maximum independence and retain control over their lives. We are especially proud of the contribution made by our workforce. Staff have been provided with joint training, single management and one base. As a result, they have very quickly broken down unhelpful boundaries and started to deliver co-ordinated care.

9. These are crucial steps in shaping a sustainable social care system for the Vale that is capable of meeting the considerable demands that will be placed on it in the future. Focusing on the delivery of preventative care helps people to maintain their independence at home, while also helping to reduce demand on acute hospital services and the need for long-term residential care.

10. We can demonstrate then that some of our ambitious programmes of change are having an impact at the front-line - the place where they make a real difference to people's lives. There are similar changes occurring across the whole range of adult services including those for people with a physical disability, a learning disability or mental health problems. Further progress requires even more integrated working across social care and health services and strategic 'pooling' not only of financial budgets but also the skills of practitioners and senior managers across both sectors. We are determined to take forward this work at scale and at pace, as part of our efforts to drive delivery of new service models that better reflect what people want and need if they are to remain independent.

11. Adult Services have increased the number of people supported at home while reducing the number supported in a care home setting. This is in line with the way in which the Council plans to deal with the challenges brought about by increasing demand for services and the changing expectations of our service users who tell us that they would prefer to maintain their independence at home. Older residents are receiving more home care , in contrast to those under 65. The size of individual care packages has also increased, indicating that we are meeting the needs of people with more complex difficulties. It is disappointing then to see an increase in the annual figure for delayed transfers of care (DTOC) from hospital, despite the fact that a number of new initiatives have been put in place, such as the Vale Community Resource Service and a more integrated approach to hospital discharge. However, the beginning of 2013 saw unprecedented winter pressures in the hospital system and this was followed by temporary difficulties in staffing the Integrated Discharge Service. This team is now fully staffed and the figures in respect of delays in the second half of the year show a marked improvement.

12. Similarly, following several years of growth in the use of Telecare services, progress has stalled in 2013/14. The Telecare team has been relocated to ensure that it has good links with the Vale's contact centre and some temporary staffing issues have been resolved. It is expected that more people will be supported with Telecare services in the future.

13. Adult social care services across Wales are currently provided subject to a formal financial assessment. If people have sufficient disposable resources and can pay for services, they are required to do so. Since April 2011, the Welsh Government has set a maximum charge of £50 per week for non-residential care. This change in policy has had a significant

effect in the Vale. It has increased the workload of the service and considerably reduced the income it can generate. Together with increasing costs for care in institutional settings and rising demand because of changes in the population, the effect has been to create significant pressure on both Adult Services budgets and operational delivery. The service continues with its rigorous budget plan in order to achieve essential savings in a very challenging context and will have to remodel service delivery to cope with the additional demand.

14. The Integrating Health and Social Care Services Programme is in place to increase the scale and pace of work to join up health and social care services across the Cardiff and Vale region where there are clear benefits to service users and patients. The Programme includes the following partners:

- the Vale of Glamorgan Council;
- Cardiff Council;
- Cardiff and Vale University Health Board;
- Vale Centre for Voluntary Services; and
- Cardiff 3rd Sector Council.

15. A Statement of Intent has been prepared by all the partners in response to the Welsh Government's Framework for Older People's Services. It commits the organisations to increasing the scale and pace of our work together so that we can deal with issues such as planning how to deal with winter pressures. The partnership has also developed its own Framework for Older People; it outlines the agreed vision for older people's services over the next five years.

16. Short-term funding has been made available by the Welsh Government to develop new models of service for older people in order to achieve the vision outlined above. This money has been awarded via the Regional Collaboration Fund (RCF) and it is funding initiatives to improve unified assessment, reablement and assistive technology services and to deliver the local Dementia Plan.

17. . Further change is planned in the Vale locality assessment and care management services for older people, to ensure integration with health services while achieving the best use of resources and closer collaboration with neighbouring authorities. It is intended to take the strategic direction from Welsh Government's "Delivering Local Health Care – Accelerating the Pace of Change" and support the joint development of fully integrated locality services in the community.

18. Plans have been developed to ensure that each service area responds to the needs of Welsh speakers in line with the strategic guidance from Welsh Government “More than Just Words”.

SERVICES FOR PEOPLE WITH A LEARNING DISABILITY

19. Assessment and care management is carried out by a multi-agency team which works together to address the health as well as social care needs of people with a learning disability. It is well placed to take forward plans for increased integration of services with Cardiff Council and with the Cardiff and Vale University Health Board.

20. Considerable changes have been made to Day Services since 2011. The service has recognised the need to develop a strategic vision for day opportunities and will be taking this work forward in collaboration with Cardiff Council. We have sought to take forward in 2013/14 a project to ensure that day care takes place in and the relocation of the Woodlands days service has been achieved. The service is focusing on modernising day opportunities, including a move away from a building-based model of provision. It will be seeking ways to work in partnership with a variety of organisations to deliver a model of provision that is more centred on meeting the specific assessed needs of individual service users.

21. The improvements already achieved in supported accommodation services have been enhanced through the process of retendering contracts with independent sector providers. Given the increasing need for this type of provision, the Community Support Team continues to explore options for expanding the number of properties that can be used as supported accommodation. We have reviewed our respite care provision to ensure that service users can get access to the setting most appropriate for their needs. Work with the Third Sector is underway, through the Learning Disability Partnership Group, to explore with stakeholders how respite services may be delivered more flexibly in the future.

22. We have ensured that service users living in supported and other accommodation can make full use of Telecare equipment, to live more independently.

23. These were our improvement priorities for 2013/14 and the progress made:

- In collaboration with Cardiff Council and following consultation with a number of stakeholders, we have completed a Day Opportunities Strategy which will help us to remodel day service provision. Detailed actions plans have been put in place for each local authority for 2014-2017.

- We have closed Woodlands Day Centre and successfully relocated the service to a more suitable building. We are currently in the process of reviewing Day Opportunities to ensure the service delivery model meets need and demand appropriately.

  "I like the new space and I get to see more of my friends'- former Woodlands Service User

Our improvement priorities for 2014/15

- **We will implement the Day Opportunities Strategy and action plans, to ensure that people are enabled to participate in meaningful and more typical day time activities and to maximise their independence.**

- **We will work with the Vale of Glamorgan Housing Service and Registered Social Landlords to expand the range of housing and accommodation options available and to ensure that agreed outcomes emphasise how services will help people to develop their capacity for independence including support and access to mainstream housing.**

- **Relocate the Community Support Team to Hen Goleg and in collaboration with our partners look at further ways of integrated working.**

SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

24. Community Mental Health Services in the Vale of Glamorgan are organised around three integrated Community Mental Health Teams (CMHTs) with responsibility for providing accessible mental health services for adults with severe mental health problems based on a Community Care Assessment and a Care and Treatment Plan.

25. Each CMHT is led by an Integrated Manger who is responsible for the operation of a joint health and social care pathway which includes access to social workers, social care officers and carers officer as well as relevant health colleagues (including psychiatrists and community psychiatric nurses).

26. The teams have seen a significant increase in referrals from Vale of Glamorgan GPs, with an increasing expectation of high quality, rapid assessments and risk management. This has placed unprecedented demand pressures on the teams and they have had to focus an increasing proportion of their resources (including social work capacity) on the screening, assessment and management of referrals.

27. The Carers Support Officer is now an integral part of the team; this has meant more effective and timely assessment of carers' needs. It is an approach that aligns well with the work that Hafal provides on behalf of the Council in supporting individual carers and operating carers' support and activity groups.

28. The Mental Health Community Support Workers are continuing to develop their recovery focused community interventions to support some very vulnerable people through to greater levels of independence. The Team has worked with Vale MIND to develop an integrated outcome measurement approach using the 'Recovery Star' approach. It is intended that all community support work services across Cardiff and Vale will use this single approach to measure the progress made by service users and service effectiveness.

29. Approved Mental Health Practitioner (AMHP) work continues to increase in terms of undertaking Mental Health Act Assessments, as well as supporting the Mental Health Review Tribunal process and assisting in the creation of Community Treatment Orders. Last year, we sponsored one social worker to undertake the AMHP training and we are keen to support

more staff through the training so that we can meet the growing demand for these services.

30. Within the overall Integrating Health and Social Care Services Programme for the Vale of Glamorgan and Cardiff, there is a specific project for mental health services. The Mental Health Partnership Board is taking responsibility for local implementation of the Welsh Government's 'Together for Mental Health' Strategy which takes a cross departmental view of mental health promotion for all citizens in Wales. This local delivery plan challenges the local authority to promote mental wellbeing of its employees and all of its customers through every contact.

31. These were our improvement priorities in 2013/14 and the progress made:

- **Mental Health services in the Vale have taken a more joined up approach with Vale Housing and the Safer Vale Partnership to ensure that people's mental health is promoted across all sectors through representation on the Vale Problem Solving Group and by encouraging more open dialogue to ensure people with housing difficulties or at risk of homelessness do not face additional barriers to mental health services.**

- **We have established joint arrangements with the University Health Board in the delivery and commissioning of community mental health services and agreed shared ways of monitoring outcomes for the CMHTs and 3rd sector commissioned services.**

Our improvement priorities for 2014/15

- **We will consult with Cardiff Council and the Cardiff and Vale UHB upon a joint Commissioning Strategy for Mental Health Services.**
- **We will explore with our partners the cost and benefits of re-organising the provision of CMHTs, to ensure our services are able to meet the challenge of increasing demand and expectations from primary care referrers while continuing to offer quality secondary care interventions.**
- **We will continue to work with Vale of Glamorgan Housing to develop innovative and cost effective housing and support options.**

SERVICES FOR PEOPLE WHO ARE FRAIL BECAUSE OF AGEING

32. Adult social care for older people includes:

- assessment and care management
- nursing and residential care homes
- respite care
- community services (home care, day care, meals)
- re-ablement to prevent hospital admission or enable continued independence
- intermediate care (after a spell in hospital)
- supported and other accommodation (including adult placement and extra care)
- direct payments to service users
- safeguarding
- the provision of equipment and related areas (including telecare).

33. Adult services continue to build on the reablement model to promote independence, reducing the need for long term intensive domiciliary packages of care and the pressure to accommodate the older people inappropriately in residential care settings.

34. 2013/14 has continued to see increasing demands for older people's services and it is anticipated that this trend will continue for the foreseeable future. This has put further strain on the services currently available and care co-ordinators have been seeking innovative ways to meet the assessed needs of service users. Making use of third sector partnerships and extending integrated working with both the NHS and neighbouring local authorities has helped us to do so in a collaborative way.

35. Although most services provide reasonable response times with the average number of days between enquiry and delivery of care being 18

days, a waiting list has existed for much of the year within our Adult Community Care Team (ACCT), despite initiatives designed to meet rising demand by changing service patterns. Staffing in the team is generally stable and several staff members have returned from long term sickness in the second half of the year. We have ensured that there are robust systems to ensure that referrals and allocation are prioritised effectively.

36. Occupational Therapy teams have built on the significant improvements in the waiting times for services made in 2012/13. The 'Assess and Provide' service continues to contribute to our improved waiting times. The service has benefited from having a fully established staff group whilst welcoming some new members to the team. Additional staff within the Disabled Facilities Grant (DFG) team within the Council Development has further reduced the time taken for processing the cases.

37. All stakeholders now recognise that, in order to meet the growing demand for support and care in the future with fewer resources, we need to reconsider how our Older People's services are configured. We are building a new locality based plan for remodelling our service and developing greater levels of integration with health partners. It is our intention for this to be implemented in the first half of the next financial year.

38. Community Mental Health Older Persons (CMHOP) team has continued to manage well its waiting times, although with some growth in the final quarter. Despite this increase, the CMHOP has not returned to the high numbers reported two years ago.

39. Ongoing implementation of the Mental Health Measure has provided a clear focus for the work of this team. One consequence has been that individuals who previously met the eligibility criteria for services from this team are now receiving services from the Adult Community Care Team, contributing to the increase in demand and complexity of the workload of the ACCT team.

40. An Integrated Discharge Service has been operational since November 2012. This has brought together hospital social work, discharge liaison nursing and third sector support to help facilitate timely discharge for those with complex needs. This service is now more established and closer collaborative arrangements are being built upon with Cardiff Adult Services staff.

> "The Integrated Discharge Service is innovative in its scope and intention and when fully implemented should become an area of good practice" – *CSSIW (site visit report)*

41. These were our improvement priorities for 2013/14 and the progress made.

- **We have extended the eligibility criteria for the Vale Community Resource Service to maximise the throughput of cases and support hospital discharge, and prevent hospital admission;**
- **We have made some progress in fully implementing the Integrated Discharge Service model and are building on preliminary steps now that the team is fully staffed;**

Our improvement priorities for 2014/15

- **We will reconfigure Locality Services to deliver a more integrated model of health and social care services that can meet the demands of the population in the future.**

- **We will consider the extent to which Telecare can be used to better support people with dementia and consider strategies to increase its uptake.**

- **Implement a joint communications hub which will complete screening, signposting, prioritisation and promote well-being.**

SERVICES FOR PEOPLE WITH A PHYSICAL DISABILITY OR SENSORY IMPAIRMENT

42. In the face of rising demand and changing expectations about the range of services needed by an ageing population and on seeing an increase in the numbers of people with profound disabilties, social services have encouraged a reablement approach to care and to reducing pressure to accommodate growing numbers of people in residential settings inapproriately. This involves developing the use of assistive technology and reconfiguring services through moving from traditional, high cost services (which do not deliver good outcomes for people or even keep them safe from abuse at times) in favour of more preventative models. There is a focus on partnership with other local authorities, the NHS, the third and private sectors in order to achieve these aims through maximising efficiency and ensuring that people are supported proportionately and in ways that maintain independence as long as possible.

43. Throughout 2013/14, development work has been concentrated on reablement and rehabilitation. This has built upon the co-location of health and social care staff and a fully integrated model became operational in February 2014. The services have been able to demonstrate significant improvements in facilitating faster arrangements for safe discharge and higher levels of independence. The service receives a high number of compliments and reports very high levels of service user satisfaction.

> "Thank you all for the care that you have given me. You have a wonderful lot of helpers and believe me they are wonderful. The care they take to encourage us when they see us doing well" – *VCRS Service User*

> *CASE STUDY: A service user interview following VCRS intervention.*
>
> *Case Study – BW*

> *The W family have been through some very difficult times. Mrs. W tells me about the spinal problems and chronic back pain with which she has coped for much of her life – in fact since the age of 5 when she first started going to hospital for physiotherapy sessions 3 days a week.*

There have been various instances throughout her life when she has been unable to walk, and various diagnoses as to what the underlying problems might be. Mrs. W talks about the numerous hospitals that she has visited over that time and the ways in which she's tried to help herself at home to keep life going in between those times.

Most recently, events came to a head in April, 2013 when Mrs. W fell in her hallway. She remembers feeling dizzy and then falling away from her Zimmer frame. This was the latest of a number of similar falls. After spending a night in A&E, Mrs. W returned home with strong painkillers "which knocked me out – I seemed to be out of it for most of the first few weeks back home". In fact Mrs. W appeared to have been in bed for the majority of those 2 weeks.

Then one day, Phil the Physiotherapist arrived. "That was the first time I felt anyone was interested in me. My husband was getting thin and ill with worry." The Physiotherapists provided Mrs. W with a frame to get out of bed, an elevated toilet seat and a seat for the shower. "It was their first visit - I thought, 'well they're lovely!'".

"They'd tell me what to do – didn't pull me out of bed. They trained me so I wouldn't fall. They don't touch you, they don't walk you in… they tell you how to do it and make you do everything yourself. They were marvellous. I had carers come in – 2 in the morning and 2 at night. If someone holds you up and plonks you down on the toilet and things like that, well you don't learn. We'd have a laugh – they'd come upstairs and tell me what the downstairs and garden looked like. They seemed to watch all the time to see what I could and couldn't do."

Mr. W said, "Enfys, the OT – she was wonderful – she sorted Mrs W out and wouldn't let her give in. The Physios gave her all the exercises to keep her legs moving. They helped such a lot – took quite a lot off my shoulders – especially in the mornings and evenings. Mrs W is quite a private person – she didn't really want me taking her to the toilet. I can't think of any people who could have done more for us. Mentally as well, they chatted with you – they were friendly."

Mrs. W agrees: "they give me a little bit of independence. They give me a little bit of confidence back. Giving me the kit, that helps with independence but being told how to use them… that's what makes the difference. If I hadn't had them, I would have stayed in my bed forever. They don't treat you as if you're a lump of meat that you've got to get up and brush down. While they're here, it's as if a friend has come to see you".

In his last visit, Phil the Physiotherapist was able to walk with Mrs. W around her garden – and she's done it herself on numerous occasions since then. Mr. W has noticed that she hasn't needed to take so many pain killers recently, and that his wife hasn't fallen as often.

44. A small scale, specialist service for Sensory Impairment is provided through the Adult Community Care and Occupational Therapy Teams. It offers specialist assessment and care management, reablement for visual impairment and equipment services to meet the needs of adults with sensory loss. This year we have continued to maintain low numbers waiting for specific input from a Rehabilitation Officer for Visual Impairment, building on progress made in 2012/13.

45. These were our improvement priorities for 2013/14 and the progress made:

- **We have decided not to develop a commissioning strategy for people with Physical Disabilities at this time. We have concentrated instead on preparing for the consequences of changes to the Independent Living Fund and on exploring shared opportunities with providers of Learning Disability Services.**

- **We will be opening the Extra Care facility 'Golau Caredig' in July 2014. This will provide accommodation to allow us to accommodate some people who receive physical disability services and we will then look again at identifying gaps in the provision of placements and accommodation.**

Our improvement priorities for 2014/15

- **We will extend the reablement service so that more people have the opportunity to maximise their potential for achieving independence**

- **We will ensure that the new Extra Care Development is fully used as an alternative to more institutional models of care.**

SERVICES FOR PEOPLE WITH AUTISM

46. This is another area where we are able to demonstrate significant innovation and improvement.

- Our online learning tool won a national award and has been adopted by seven other local authorities to help develop awareness of autistic spectrum disorders.

- A regional monitoring and support project has been established, led by the Vale of Glamorgan. The support project runs across Cardiff, Rhondda CynonTaf and Merthyr Tydfil to provide assistance to people with autism who do not require case managed social care provision. This service is highly valued by those who have used it.

  "All of the staff that I've met through Adult Autism Advice were brilliant, and by far the most helpful people I've encountered since my diagnosis" – Autism Advice service user

- We have facilitated the development of user-led socialisation groups, including a monthly forum for adults to exchange views and to inform future service direction within services, an evening social group for higher functioning adults and a peer support group for couples where one or both of the partners is on the autistic spectrum.

- We have delivered autism training and awareness to a wide range of staff and external organisations such as education staff, care providers, homeless services and eating disorder clinicians.

- Our improvement priorities for 2013/14 have been implemented;

- **We have completed the 'employment prospects' project for adults on the autistic spectrum and rolled out the job skills workshops.**

- **We have completed the research and development phase of the online employment and skills information resource for individuals, carers and professionals.**

- **We have completed the development of the online resource to provide recipes and cooking skills for individuals with Autism. This will increase independence and improve health and wellbeing, with less reliance on pre-prepared and processed meals.**

Our priorities for 2014/ 2015

- **We will continue to implement the 'employment prospects' project for adults on the autistic spectrum and deliver workshops jointly with job centre plus. Staff will then use the materials created by the project to work directly with individuals.**
- **We will further develop an online presence for the employment and skills information resource for individuals, carers and professionals.**
- **We will deliver training for Day Services staff working with adults on the autistic spectrum.**

SERVICES FOR PEOPLE WHO HAVE SUBSTANCE MISUSE PROBLEMS

47. We are working closely with the Vale Community Safety Partnership and Cardiff Council, in particular as members of the multi-disciplinary Area Planning Board which operates across the two local authority areas. By working closely with the voluntary sector, and with the development of the single point of entry into Drug and Alcohol Services (EDAS), we continue to offer rapid access to assessments and appropriate interventions

48. We have supported six people through residential rehabilitation in the last year. However, we are aware that people wish to receive rehabilitation services closer to home. We will explore the development of social care support options for people accessing local NHS drug and alcohol treatment options, to help maintain motivation during this process.

49. These were our improvement priorities for 2013/14.

50. We have worked with Cardiff Council and the Cardiff and Vale UHB in the development of a model for specialist residential care for people with acquired alcohol brain injury.

51. **We have developed links with specialist providers of domiciliary care for people who misuse substances so that people can live independently at home while using treatment services.**

Our priorities for 2014/2015

- **We will explore how to develop support options for people accessing local NHS drug and alcohol treatment options, to help maintain motivation during this process.**
- **We will continue to work with local providers of social care support to improve their skills and experience of providing support services to people using substances and those undergoing rehabilitation/treatment.**